§4204. ISSUANCE OF CERTIFICATE OF AUTHORITY

1. Procedure upon receipt of an application for issuance of a certificate of authority.

A. Concurrently with filing an application for issuance of certificate of authority with the superintendent, the applicant shall also file an application for a certificate of need pursuant to Title 22, chapter 103-A. [2003, c. 510, Pt. A, §20 (AMD).]

B. The superintendent shall take no final action with regard to the application until he has been informed by the Department of Health and Human Services whether or not the application for the certificate of need has been approved, denied or deemed not to be required. The Department of Health and Human Services shall transmit to the superintendent a copy of its written decision on the application for a certificate of need. [1981, c. 501, §49 (AMD); 2003, c. 689, Pt. B, §6 (REV).]

[2003, c. 510, Pt. A, §20 (AMD); 2003, c. 689, Pt. B, §6 (REV) .]

2.

[1981, c. 501, §50 (RP) .]

2-A. The superintendent shall issue or deny a certificate of authority to any person filing an application pursuant to section 4203 within 50 business days of receipt of the notice from the Department of Health and Human Services that the applicant has been granted a certificate of need or, if a certificate of need is not required, within 50 business days of receipt of notice from the Department of Health and Human Services that the applicant is in compliance with the requirements of paragraph B. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section 4220 if the superintendent is satisfied that the following conditions are met.

A. The Commissioner of Health and Human Services certifies that the health maintenance organization has received a certificate of need or that a certificate of need is not required pursuant to Title 22, chapter 103-A. [2003, c. 510, Pt. A, §21 (AMD); 2003, c. 689, Pt. B, §7 (REV).]

B. If the Commissioner of Health and Human Services has determined that a certificate of need is not required, the commissioner makes a determination and provides a certification to the superintendent that the following requirements have been met.

(4) The health maintenance organization must establish and maintain procedures to ensure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. These procedures must include mechanisms to ensure availability, accessibility and continuity of care.

(5) The health maintenance organization must have an ongoing internal quality assurance program to monitor and evaluate its health care services including primary and specialist physician services, ancillary and preventive health care services across all institutional and noninstitutional settings. The program must include, at a minimum, the following:

(a) A written statement of goals and objectives that emphasizes improved health outcomes in evaluating the quality of care rendered to enrollees;

(b) A written quality assurance plan that describes the following:

(i) The health maintenance organization's scope and purpose in quality assurance;

(ii) The organizational structure responsible for quality assurance activities;

(iii) Contractual arrangements, in appropriate instances, for delegation of quality assurance activities;

(iv) Confidentiality policies and procedures;

(v) A system of ongoing evaluation activities;

(vi) A system of focused evaluation activities;

(vii) A system for reviewing and evaluating provider credentials for acceptance and performing peer review activities; and

(viii) Duties and responsibilities of the designated physician supervising the quality assurance activities;

(c) A written statement describing the system of ongoing quality assurance activities including:

(i) Problem assessment, identification, selection and study;

(ii) Corrective action, monitoring evaluation and reassessment; and

(iii) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(d) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies the method of topic selection, study, data collection, analysis, interpretation and report format; and

(e) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

(6) The health maintenance organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes must be available to the Commissioner of Health and Human Services.

(7) The health maintenance organization shall ensure the use and maintenance of an adequate patient record system that facilitates documentation and retrieval of clinical information to permit evaluation by the health maintenance organization of the continuity and coordination of patient care and the assessment of the quality of health and medical care provided to enrollees.

(8) Enrollee clinical records must be available to the Commissioner of Health and Human Services or an authorized designee for examination and review to ascertain compliance with this section, or as considered necessary by the Commissioner of Health and Human Services.

(9) The organization must establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

The Commissioner of Health and Human Services shall make the certification required by this paragraph within 60 days of the date of the written decision that a certificate of need was not required. If the commissioner certifies that the health maintenance organization does not meet all of the requirements of this paragraph, the commissioner shall specify in what respects the health maintenance organization is deficient. [2013, c. 588, Pt. A, §29 (AMD).]

C. The health maintenance organization conforms to the definition under section 4202-A, subsection 10. [1991, c. 709, §3 (AMD).]

D. The health maintenance organization is financially responsible, complies with the minimum surplus requirements of section 4204-A and, among other factors, can reasonably be expected to meet its obligations to enrollees and prospective enrollees.

(1) In a determination of minimum surplus requirements, the following terms have the following meanings.

(a) "Admitted assets" means assets recognized by the superintendent pursuant to section 901-A. For purposes of this chapter, the asset value is that contained in the annual statement of the corporation as of December 31st of the year preceding the making of the investment or contained in any audited financial report, as defined in section 221-A, of more current origin.

(b) "Reserves" means those reserves held by corporations subject to this chapter for the protection of subscribers. For purposes of this chapter, the reserve value is that contained in the annual statement of the corporation as of December 31st of the preceding year or any audited financial report, as defined in section 221-A, of more current origin.

(2) In making the determination whether the health maintenance organization is financially responsible, the superintendent may also consider:

(a) The financial soundness of the health maintenance organization's arrangements for health care services and the schedule of charges used;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a nonprofit hospital or medical service corporation, a government or any other organization for insuring or providing the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan;

(d) Any agreement with providers for the provision of health care services that contains a covenant consistent with subsection 6; and

(e) Any arrangements for insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of health care services. [2007, c. 466, Pt. D, §7 (AMD).]

E. The enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to section 4206. [1981, c. 501, §51 (NEW).]

F. Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 4203 or by independent investigation, is contrary to the public interest. [1981, c. 501, §51 (NEW).]

G. Any director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of that organization shall be responsible for those funds in a fiduciary relationship to the organization. [1989, c. 842, §10 (NEW).]

H. The health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on those employees and officers of the health maintenance organization who have duties as described in paragraph G, in an amount not less than $250,000 for each health maintenance organization or a maximum of $5,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the superintendent. [1989, c. 842, §10 (NEW).]

I. If any agreement, as set forth in paragraph D, subparagraph (2), division (c), is made by the health maintenance organization, the entity executing the agreement with the health maintenance organization must demonstrate to the superintendent's satisfaction that the entity has sufficient unencumbered surplus funds to cover the assured payments under the agreement, otherwise the superintendent shall disallow the agreement. In considering approval of such an agreement, the superintendent shall consider the entity's record of earnings for the most recent 3 years, the risk characteristics of its investments and whether its investments and other assets are reasonably liquid and available to make payments for health services. [1995, c. 332, Pt. O, §2 (AMD).]

J. [2001, c. 410, Pt. A, §8 (RP).]

K. The health maintenance organization provides a spectrum of providers and services that meet patient demand. [1993, c. 702, Pt. B, §1 (NEW).]

L. The health maintenance organization meets the requirements of section 4303, subsection 1. [1995, c. 673, Pt. D, §3 (RPR).]

M. The health maintenance organization demonstrates a plan for providing services for rural and underserved populations and for developing relationships with essential community providers within the area of the proposed certificate. The health maintenance organization must make an annual report to the superintendent regarding the plan. [1993, c. 702, Pt. B, §1 (NEW).]

N. [2011, c. 90, Pt. F, §6 (RP).]

O. Each health maintenance organization shall provide basic health care services. [1999, c. 222, §2 (NEW).]

The applicant shall furnish, upon request of the superintendent, any information necessary to make any determination required pursuant to this subsection.

[2013, c. 588, Pt. A, §29 (AMD) .]

3.

[1989, c. 842, §11 (RP) .]

3-A. **Investments.** The health maintenance organization shall invest funds only in accordance with chapter 13-A, except as follows.

A. The health maintenance organization shall maintain asset valuation reserves consistent with industry standards for management of investments by life and health insurers. [1993, c. 702, Pt. A, §12 (NEW).]

B. Notwithstanding any limitation stated in section 1156, subsection 2, paragraph D, a health maintenance organization may invest in real property or interests in real property located in the United States, held directly or evidenced by partnership interests, stock of corporations, trust certificates or other instruments and acquired:

(1) As an investment for the production of income or to be improved or developed for that investment purpose; or

(2) For the convenient accommodation of the organization's business.

After giving effect to any of those investments, the aggregate amount of investments made under subparagraph (1) may not exceed 20% of the health maintenance organization's total admitted assets; the aggregate amount of investments made under subparagraph (2) may not exceed 15% of the organization's total admitted assets; and the aggregate amount of investments made under this paragraph may not exceed 25% of the organization's total admitted assets. Investments under subparagraph (1) in any single property, including improvements on that property, may not in the aggregate exceed 2% of the corporation's total admitted assets. [1993, c. 702, Pt. A, §12 (NEW).]

C. In addition to the investments permitted under paragraph B, a health maintenance organization may invest in real estate, including leasehold estates, for the convenient accommodation of its business, including hospitals, medical clinics, medical professional buildings and any other facility that is to be used in the provision of health care services, or real estate for rental to an affiliated health care provider or any other health care provider under contract with the health maintenance organization to provide health care services, and that facility must be used in the provision of health care services to members of the health maintenance organization by that provider.

(1) A parcel of real estate acquired under this subsection may include excess space for rent to others if it is reasonably anticipated that that excess will be required by the health maintenance organization for expansion or if the excess is reasonably required in order to have one or more buildings that function as an economic unit.

(2) Real estate subject to this subsection may be subject to a mortgage.

(3) The admitted value of the investment may not exceed the greater of the health maintenance organization's equity or 20% of the corporation's admitted assets, and the aggregate investment in real estate held under paragraph B and under this paragraph may not exceed 40% of the corporation's admitted assets, except with the approval of the superintendent if the superintendent finds that those percentages of the corporation's admitted assets are insufficient to provide for the convenient accommodation of the health maintenance organization's business. Investments under this subsection in any single property, including improvements on that property, may not in the aggregate exceed 5% of the corporation's total admitted assets. [1993, c. 702, Pt. A, §12 (NEW).]

D. Notwithstanding any provisions of this section and chapter 13-A allowing other investments, a health maintenance organization shall maintain cash or investment grade obligations, as defined in section 1151-A, that at all times have a fair market value of not less than 100% of the organization's liability for claims payable and incurred, but not reported, claims, unearned premiums, unpaid claims adjustment expenses and, as applicable, any statutory, special or additional reserves provided by the health maintenance organization for the benefit of members as of the most recent calendar quarter prepared on the basis of statutory accounting principles. If the organization's liability for claims payable and incurred, but not reported, claims increased more than 10% prior to the end of the calendar quarter, the organization must, within 10 days of the determination, reallocate its investments to ensure compliance with this paragraph. The investments required by this paragraph constitute admitted assets of the organization. [1999, c. 715, §19 (AMD).]

E. The superintendent may establish risk-based capital standards for health maintenance organizations, their subsidiaries and controlled affiliates that engage in health care related business activities that the parent corporation conducts. [1993, c. 702, Pt. A, §12 (NEW).]

[1999, c. 715, §19 (AMD) .]

4. **Uncovered expenditures involving deposit.** A health maintenance organization shall deposit with the superintendent or, at the discretion of the superintendent, with any organization or trustee acceptable to the superintendent through which a custodial or controlled account is maintained, cash or securities that are acceptable to the superintendent and that at all times are maintained in a fair market value of not less than an amount equal to the greater of $100,000 or 120% of the health maintenance organization's liability for uncovered expenditures for enrollees as of the end of the most recent calendar quarter, including but not limited to, liability for incurred but not reported claims. If the health maintenance organization's liability for uncovered expenditures increases more than 10% prior to the end of the calendar quarter, the health maintenance organization must, within 10 days of the determination, deposit an amount sufficient to ensure compliance with this section. In the case of domestic health maintenance organizations, "enrollees" for purposes of this subsection means all enrollees of the organization regardless of residence. In the case of foreign health maintenance organizations, "enrollees" for purposes of this subsection means only those enrollees who are residents of this State.

A. The deposit required by this subsection constitutes an admitted asset of the health maintenance organization for purposes of determination of surplus. [1989, c. 842, §13 (NEW).]

B. A health maintenance organization that has made a deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash or securities of equal amount and value. There may also be withdrawn any part of the deposit in excess of the fair market value of the amount of the required deposit. Deposits, substitutions or withdrawals may be made only with the prior written approval of the superintendent. [1989, c. 842, §13 (NEW).]

C. The deposit required by this subsection must be held in trust and must be used only as provided under this section. The superintendent may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees for uncovered expenditures. [1989, c. 842, §13 (NEW).]

D. The superintendent may by rule or order require a health maintenance organization to file annual, quarterly or more frequent reports of a health maintenance organization's liability for uncovered expenditures. The superintendent may require that the reports include an audit opinion. [1989, c. 842, §13 (NEW).]

E. The superintendent may reduce or eliminate the deposit required by this subsection if the health maintenance organization deposits cash or securities with the Treasurer of State, an insurance supervisory official in the state or jurisdiction of domicile or other official body of that state for the protection of all subscribers and enrollees in a manner substantially similar to that required by this subsection and delivers to the superintendent a certificate to that effect, authenticated by the appropriate state official holding the deposit. [1989, c. 842, §13 (NEW).]

F. The superintendent may require a health maintenance organization to continue to maintain the deposit required under this subsection after the health maintenance organization has withdrawn from the market in accordance with section 415-A. [2001, c. 88, §1 (NEW).]

[2001, c. 88, §1 (AMD) .]

5. **Liabilities.** Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid, and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of those claims.

These liabilities must be computed in accordance with rules promulgated by the superintendent upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

[1989, c. 842, §13 (NEW) .]

6. **Hold harmless.** Every contract between a health maintenance organization and a participating provider of health care services must be in writing and must set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee may not be liable to the provider for any sums owed by the health maintenance organization.

A. If the participating provider contract has not been reduced to writing as required by this subsection or the contract fails to contain the required prohibition, the participating provider may not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. [1989, c. 842, §13 (NEW).]

B. No participating provider or agent, trustee or assignee of the participating provider, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization. [1989, c. 842, §13 (NEW).]

C. In addition to the other provisions in this subsection, if a petition to liquidate an insolvent health maintenance organization is filed with a court of competent jurisdiction, then after the date of filing the petition for liquidation:

(1) Any provider who has rendered a covered service for a subscriber or enrollee of the insolvent health maintenance organization is prohibited from collecting or attempting to collect from the subscriber or enrollee amounts normally payable by the insolvent health maintenance organization; and

(2) A provider or agent, trustee or assignee of the provider may not maintain any action at law against a subscriber or enrollee of the insolvent health maintenance organization to collect amounts for covered services normally payable by the insolvent health maintenance organization.

Nothing in this subsection prohibits a provider from collecting or attempting to collect from a subscriber or enrollee any amounts for services not normally payable by the insolvent health maintenance organization, including applicable copayments or deductibles. [2001, c. 88, §2 (NEW).]

[2001, c. 88, §2 (AMD) .]

7. **Continuation of benefits.** The superintendent shall require that each health maintenance organization have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until those covered persons are discharged or upon expiration of benefits. In considering such a plan, the superintendent may require:

A. Insurance adequate to cover the expenses to be paid for continued benefits after an insolvency; [1989, c. 842, §13 (NEW).]

B. That the provider contract obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities; [1989, c. 842, §13 (NEW).]

C. That insolvency reserves be provided and maintained for that period of claims exposure of a health maintenance organization during which a provider's termination of services is pending pursuant to subsection 8; and [1989, c. 842, §13 (NEW).]

D. Any other arrangements to ensure that benefits are continued as specified in this section. [1989, c. 842, §13 (NEW).]

[1989, c. 842, §13 (NEW) .]

8. **Notice of termination.** An agreement to provide health care services between a provider and a health maintenance organization must require that, if the provider terminates that agreement, the provider shall give the health maintenance organization not less than 60 days' notice in advance of termination. That agreement must not require more than 90 days' notice after an initial participation period not to exceed 6 months. If the health maintenance organization has a net loss of 5 or more primary care physicians in any county in any 30-day period, the health maintenance organization shall notify the Bureau of Insurance in writing within 10 days of acquiring knowledge of that loss.

[1989, c. 842, §13 (NEW) .]

9. **Denial.** A certificate of authority may be denied only after compliance with the requirements of section 4219.

[1989, c. 842, §13 (NEW) .]

SECTION HISTORY
1975, c. 293, §5 (AMD). 1975, c. 503, (NEW). 1979, c. 216, §§2-5 (AMD). 1981, c. 501, §§49-51 (AMD). 1985, c. 704, §6 (AMD). 1989, c. 345, §1 (AMD). 1989, c. 842, §§8-13 (AMD). 1991, c. 709, §3 (AMD). RR 1993, c. 1, §67 (COR). 1993, c. 313, §32 (AMD). 1993, c. 702, §§A12,B1 (AMD). 1995, c. 332, §§I1,2,O2 (AMD). 1995, c. 673, §D3 (AMD). 1999, c. 222, §2 (AMD). 1999, c. 715, §19 (AMD). 2001, c. 72, §19 (AMD). 2001, c. 88, §§1,2 (AMD). 2001, c. 410, §A8 (AMD). 2003, c. 510, §§A20,21 (AMD). 2003, c. 689, §B6 (REV). 2007, c. 466, Pt. D, §7 (AMD). 2011, c. 90, Pt. F, §6 (AMD). 2013, c. 588, Pt. A, §29 (AMD).